APPLICATION FOR THE MEDICARE SAVINGS PROGRAMS

The State of Washington Department of Social and Health Services (DSHS) has programs to help you pay some of your Medicare expenses. These programs are for a person who is eligible for or enrolled in Medicare Part A.

QMB
Qualified Medicare Beneficiary

This program is for the Medicare Part A eligible person who has limited assets and income which is at or below 100% of the Federal Poverty Level (FPL). The QMB program pays for Medicare Part A if needed, Medicare Part B premium and covers Medicare deductibles, coinsurance charges, and co-payments.

SLMB
Specified Low-Income Medicare Beneficiary

This program is for the Medicare Part A eligible person who has limited assets and income which is more than 100% of the FPL but less than 120% of the FPL. The SLMB program provides for payment of the Medicare Part B premium only.

Qualified Individual (Q-1) - ESLMB
Expanded Specified Low-Income Medicare Beneficiary

This program is for the Medicare Part A eligible person who has limited assets and income which is more than 120% of the FPL but less than 135% of the FPL. Persons cannot be Medicaid eligible and receive QI-1. The QI-1 program provides for payment of the Medicare Part B premium only. Funding for this program is limited.

HOW DO I QUALIFY?

1. You must be able to get Medicare Parts A and B.
2. Your assets, such as bank account, stocks and bonds cannot exceed $4,000 for one person or $6,000 for a couple. The assets and income of your spouse are counted even though your spouse may not be getting Medicare or applying for benefits.
3. Your income must be within the limits of each program. These income limits are updated yearly.
4. To apply or ask further questions, contact the DSHS Community Services (CSO) that serves the area where you live. **Check your telephone book in the state government pages under Social and Health Services or Community Services Office to find the telephone number of the CSO nearest you.**

HOW DO I APPLY?

1. Complete the attached application for the QMB, SLMB, and QI-1 (or ESLMB) programs.
2. Attach a copy of your red, white and blue Medicare card (front and back) and your personal identification. Also attach a copy of your insurance card (front and back), if you have other health insurance. **Please send copies, not originals.**
3. Mail the application and copies of documents listed above to your local CSO.
4. It may take up to 45 days from the date DSHS receives your application until the application process is completed. If you do not hear from DSHS within 20 days, call your Community Services Office (CSO) to ask about the status of your application.

IF YOU NEED CASH, MEDICAL OR FOOD ASSISTANCE, YOU MUST COMPLETE A DIFFERENT APPLICATION. PLEASE CALL YOUR COMMUNITY SERVICES OFFICE (CSO) AND THEY WILL SEND YOU THE PROPER FORM.

APPLICATION FOR MEDICARE SAVINGS PROGRAMS

Please read the following before completing the application.

You will need to answer all questions before we will know if we can help you. If you need help completing any part of this form, call your local Community Services Office.

STEP #1 Please print.

1. FIRST NAME	MIDDLE INITIAL	LAST NAME	
2. RESIDENCE ADDRESS	CITY	STATE	ZIP CODE
3. MAILING ADDRESS (IF DIFFERENT)	CITY	STATE	ZIP CODE

4. TELEPHONE NUMBERS	5. DO YOU HAVE TROUBLE SPEAKING, READING OR WRITING ENGLISH?
HOME	☐ YES ☐ NO
MESSAGE	DO YOU NEED AN INTERPRETER? ☐ YES ☐ NO IF YES, WE WILL PROVIDE ONE. WHAT LANGUAGE DO YOU SPEAK? _____

GENERAL INFORMATION

IF MARRIED, LIST SPOUSE ALSO. USE LEGAL NAMES.

NAME (FIRST, MI, LAST)	RELATIONSHIP TO YOU	DATE OF BIRTH	APPLYING FOR BENEFITS? YES NO	SOCIAL SECURITY NUMBER	SEX M OR F
	SELF				
	SPOUSE				

MEDICAL COVERAGE INFORMATION

CHECK WHICH APPLIES			MEDICARE NUMBER
Eligible for or receiving: Medicare Part A	Self	Yes ☐ No ☐	
	Spouse	Yes ☐ No ☐	
Eligible for or receiving: Medicare Part B	Self	Yes ☐ No ☐	
	Spouse	Yes ☐ No ☐	

I/we have other medical coverage. Yes ☐ No ☐

If yes, what insurance and whom does it cover?

_____

_____

Did you pay Medicare premiums for Medicare Part A or Part B in the last 3 months ? Yes ☐ No ☐

If so, please tell us which months _____

INCOME

For each person that you included on this application who has income, list the income below. List the income amount before deductions (such as taxes or insurance) are taken out. Income includes but is not limited to:

- Wages
- Self- employment
- Commissions
- Room and Board/Rent
- Railroad Benefits
- Social Security Benefits Insurance
- Veterans Benefits
- Alimony Benefits
- Unemployment or Worker Compensation
- SSI/Public Assistance
- Pensions/Retirement
- Dividends and Interest
- Other

NAME	EMPLOYER OR SOURCE OF INCOME	AMOUNT BEFORE DEDUCTIONS	HOW OFTEN RECEIVED?

ASSETS

A. My assets are under $4,000 for one person or $6,000 for a couple. Assets include such things as bank accounts, certificates of deposit, savings bonds, IRAs, stocks and bonds, mutual funds, cash, property other than your home or automobile. Yes ☐ No ☐

If yes, please list below:

NAME OF OWNER	TYPE/ACCOUNT NUMBER OF THE ASSET	CURRENT VALUE

B. Do you or your spouse own or are you buying a car or other vehicle (truck, boat, motor home, motorcycle, camper and/or trailer?) Yes ☐ No ☐

If yes, please list below:

NAME OF OWNER	ITEM	YEAR	MAKE/MODEL	USED FOR TRANSPORTATION TO MEDICAL APPOINTMENTS	VALUE	AMOUNT OWED
				Yes ☐ No ☐		
				Yes ☐ No ☐		
				Yes ☐ No ☐		

C. Do you or your spouse have a whole life insurance policy with cash value over $1,500.00? Also list any burial insurance or burial plans. Yes ☐ No ☐

If yes, please list below:

POLICY OWNER	NAME OF INSURANCE COMPANY/POLICY NUMBER	FACE VALUE	CASH VALUE	WHO IS COVERED?

READ CAREFULLY BEFORE SIGNING

I UNDERSTAND THAT:

- I must report immediately to the Department of Social and Health Services (DSHS), in writing, or by telephone, any changes in my situation. Late reporting may cause incorrect benefits.
- My situation is subject to verification by DSHS or other state or federal agencies.
- I must provide proof when asked to be eligible for help. DSHS may help me obtain the proof or contact other persons or agencies for it.
- By asking for and receiving medical care benefits, I assign to the state of Washington all rights to any medical support, and to any third party payments for medical care.

DECLARATION AND SIGNATURE(S)

I have read and understood the information in this application. I declare, under penalty of perjury, the information I have given in this application is true, correct, and complete to the best of my knowledge.

SIGNATURE OF APPLICANT		DATE
SIGNATURE OF SPOUSE		DATE
SIGNATURE OF PERSON ASSISTING APPLICANT	ORGANIZATION	DATE

RELEASE OF INFORMATION	
I authorize DSHS to release information regarding my application for the Medicare Savings Programs to the person assisting with completion of this application or representative from that person's organization.	
SIGNATURE OF APPLICANT	DATE

VOLUNTARY INFORMATION

We ask you to voluntarily tell us your race or ethnic background. This information will not be used in considering your eligibility for benefits.

☐ Caucasian ☐ Hispanic ☐ Black ☐ Native American/Alaskan Native

☐ Vietnamese/Laotian/Cambodian ☐ Tribe: _____

☐ Other Asian or Pacific Islander ☐ Other: _____

STEP #2

ATTACH PROOF

We will need some information from you to process your application. **Always send copies of documents to us, not your originals.**

- Identification — Driver's License, Passport, or Photo ID
- Medicare — Medicare ID Card (front and back)
- Other Health Insurance — Insurance Card (front and back)

If you are unable to obtain proof, DSHS can help you. Please attach a note explaining why you are unable to provide the proof.

STEP #3

Sign and date your application and return it, along with copies of your documents, to your local CSO. Call your local CSO if you need a postage paid envelope.